influenza, reducing morbidity and mortality rates not only for those vaccinated, but also for the entire population by reducing the spread of the virus. In the context of contact network epidemiology, an individual who is located in the center of the network is more likely to become infected. Thus, vaccinating such individuals before others would be more efficient in reducing the influenza burden. **METHODS:** We show that immunizing those who have been infected in the previous season, especially before the peak of the disease, can substantially reduce infection rates for a wide range of influenza viruses. Using the Susceptible Infected Recovered (SIR) compartmental model we ran 2,100,000 simulations, each reflecting two successive influenza seasons over a 1.5 million population contact network based on the Portland population. The second season was checked for a Random Vaccination Policy (RVP) and when using a vaccination policy prioritizing first those who were infected in the previous season especially before the peak (PFIP). **RESULTS:** When no vaccination is offered, individuals who became infected in the previous season have a higher probability of becoming infected in the following season. Accordingly, PFIP can reduce the number of infected by up to 80% compared to RVP, even if the cross-reactivity rate between the viruses of two seasons is as high as 60-80%. We provide a simple tool describing the conditions when each policy should be used. **CONCLUSIONS:** No CDC recommendations have ever considered the effect of a previous season on an individual in determining future vaccination policy. The PFIP can be achieved easily by sending pamphlets, telephone reminders or even family doctor recommendations to those who were diagnosed by the family doctor as suffering from influenza like illness (ILI) in the previous season.

PHS77

CANCER NETWORK PHARMACISTS PERSPECTIVE OF THE FIRST YEAR OF THE CANCER DRUGS FUND

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OBJECTIVES: The UK Government has allocated £200 million per year for three years to fund cancer drugs in England which will be managed via the Cancer Drugs Fund (CDF). There are ten CDFs in England which are largely managed by Cancer Network Pharmacists. The objective of this research was to identify from the Cancer Network Pharmacists' perspective what impact the CDF had made in the first year on cancer drug usage, practice, use of resources and also their concerns if the CDF disappeared after three years. **METHODS:** A semi structured questionnaire was developed to capture quantitative and qualitative data relating to changes in oncology drug use, clinical practice and resources for the time period 1st April 2011 to 31st March 2012.This questionnaire was also used to capture information on the Cancer Network Pharmacists concerns if the CDF disappeared after three years. The questionnaire was piloted with three Cancer Network Pharmacists. Telephone interviews were undertaken with Cancer Network Pharmacists covering the ten CDFs. The data collected was assessed and evaluated, using a thematic framework. **RESULTS:** The CDF had led to a significant increase in use of some drugs and clinical practice had changed. Workload for pharmacy both at the cancer networks and in the hospital Trusts had increased. Attendances at clinics had increased creating some capacity issues. The commissioning process for cancer drugs had changed; new drugs were not commissioned unless recommended by NICE. It was considered there would be significant risks if the CDF disappeared after three years as it was not clear how drugs funded by the CDF would then be funded and return to practice pre CDF would be difficult. **CONCLUSIONS:** The CDF had changed clinical practice for the management of certain cancers. If the CDF disappeared in 2014 it was unclear how some drugs would be funded.

PHS78

IMPACT OF EDUCATIONAL INTERVENTION ON CASE MANAGEMENT OF ARI AT COMMUNITY PHARMACIES IN ISLAMABAD PAKISTAN

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OBJECTIVES: To evaluate the impact of training of dispensers on the process of case management of ARI at community pharmacies in context to history taking and provision of advice working at community pharmacies in Islamabad, Pakistan. **METHODS:** A randomized, controlled, blinded intervention study was designed and implemented. Before the implementation of intervention, a baseline study was performed to assess the process of case management for ARI at community pharmacies. The study population included all community pharmacy outlets in Islamabad. After data collection, data was analyzed. The result of the study revealed that the overall process of disease management of ARI at community pharmacies in Pakistan is not satisfactory. Pharmacies of Islamabad which were visited in pre intervention phase (118) were divided into two geographical regions A (intervention) and B (control). From which thirty pharmacies were selected randomly from each region. The targeted group of the interventions was drug sellers. Keeping in view the results of the base line study an educational intervention was designed to improve the case management of ARI at community pharmacies in Pakistan. **RESULTS:** No significant difference ($p \leq 0.05$) was seen in the process of history taking and advice provision in case of ARI management at community pharmacies between pre and post control groups. On the other hand significant difference in the process of history taking and provision of advice for ARI was observed in the intervention group before and after training. **CONCLUSIONS:** The study has highlighted that improvements in the current dispensing practices at community pharmacies are possible through appropriate educational interventions. The dispensers have the potential to provide fast and low cost health care to the masses in the country where the presence of doctors and qualified pharmacist is low; to date they are an untapped and underutilized source in the country.

PHS79

THE ANALYSIS OF THE FORMULARY COMMITTEES IN KAZAKHSTANI REGIONS

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OBJECTIVES: To analyze the formation of formulary for specific drugs requirements at medical organizations(MOs) in Kazakhstan. **METHODS:** Questionnaires were filled in by the members of the formulary committees (FC) at MOs (79 ones from 4 regions of KZ) with different nosologies which had developed service; morbidity recording; state drug provision system through single distributors (SD). **RESULTS:** FCs mainly consisted of 34 % deputies of head doctors, 23 % pharmacists, 11 % nurses, 10 % head doctors, 8 % doctors, 1 % accountants; in only 1% of the MOs clinical pharmacologists were amongst FCs. Moreover, 72 % had not trained in the drug management; 12 % had experience a long time ago; 10 % improved qualifications in 2009-2010. The lists composed considering the profile and thus the specific needs of the MOs (77 %); lists of drugs provided by the SD (58 %); the Republican Formulary (44 %). 41 % of the MOs had access to the state register; just the third of them had instructions with authorities for the members. Similar number of the MOs had guidance/algorithms for filling in applications and accounts conductions. The applications were filled in considering the extents of previous consumptions (81 %); medical regimen (72 %); the patients' number (70%); left amount of drugs (63%); 94 % highlighted the toxicity to be considered for future lists. Amongst additional factors, experience in specific drugs usage was pointed out (56 %); 18 % claimed the insufficiency of information on tenders and vague choice criteria. Noteworthy, 15 % stated the lobbying of some of drugs manufacturers. **CONCLUSIONS:** Regardless to drugs provision by the state, there are obstacles in the formation of FCs and formularies lists at the MOs: no presence of clinical pharmacologists, no consideration of specific needs, poor training of the personnel.

PHS80

CLINICAL PRACTICE GUIDELINE MAJOR DEPRESSIVE DISORDER FOR GENERAL PRACTITIONERS

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OBJECTIVES: To develop the clinical practice guideline major depressive disorder for general practitioners in primary and secondary health care setting included the diagnosis, differential diagnosis, severity classification and medical treatments. **METHODS:** A list of 13 key elements of a CPG development process were developed that consisted of: 1) setting the review teams; 2) determining the problems; 3) determining health outcomes; 4) evidence based literature review; 5) meeting to draft the CPG; 6) formulating draft of CPG; 7) apprising the content of CPG by experts; 8) trail phase; 9) evaluating for trail phase; 10) developing the curricular for CPG training; 11) preparing for CPG training; 12) evaluating; and 13) improving the CPG related with evaluated results. **RESULTS:** There were 3 main processes in clinical practice guideline major depressive disorder for general practitioners in primary and secondary health care setting (CPG-MDD-GP) which were 1) Assessment of major depressive disorder (clinical assessment using 9Q screening tool and DSM-TR diagnostic criteria, differential diagnosis, diagnosis for major depressive disorder and coding of diagnosis) 2) Management of major depressive disorder and 3) Management of hospitalized patients. General practitioners were satisfied with the CPG-MDD-GP in trial phase. A total of 416 general practitioners in all provinces were trained to use the CPG-MDD-GP then they would be followed and evaluated. Psychiatrists in psychiatric hospitals/ institutes would be available for consultation from the general practitioners. **CONCLUSIONS:** The CPG-MDD-GP should be distributed to all general practitioners in primary and secondary health care setting. Next step, it would be useful for developing the CPG for MDD in the tertiary health care setting.

PHS81

HEALTH CARE ORGANIZATIONS/SERVICES CLUSTERING: COMPARISON OF SEVERAL TECHNIQUES USING UK DATA

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OBJECTIVES: Patients access to new drugs is particularly a challenging task in UK. English Primary Care Trusts (PCT) play a key role in facilitating the new drug's entry. The PCTs differ from each others through their behaviors and characteristics. The main purpose of this study is to bifurcate a total of 152 PCT in similar clusters having homogenous behavior, applying several clustering approaches, and to compare the different approaches **METHODS:** All available information about the PCTS is obtained from public sources and one key+ data base. A total of 64 variables were identified and classified into 5 groups according to population's profile, prescription and patient's characteristics, economic, financial as well as organizational criteria. We applied three kinds of clustering approaches: the two first, namely k-means (implemented both directly and indirectly) and Hierarchical Agglomerative Clustering (HAC) are traditional ones while the third, namely Self Organizing Map (SOM) is a variant of neural network architectures. Finally, contingency analysis and khi-square statistics were considered to encircle both dependencies and similarities between clusters **RESULTS:** Preliminary estimates have identified five clusters (for each method) that are different in their intrinsic characteristics. Contingency results reflect strong dependence between the direct k-mean and both HAC and SOM: indeed clusters are not very widely scattered between them. The chi-square (p-value) test corroborates their homogeneity. The indirect K-means reflects heterogeneity in cluster's dispersions also confirmed by